Attachment B
to Family Care Waiver
Application Pre-Print

Section B:
Access and Capacity

Assurances

Family Care Access and Capacity Assurances
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Assurances of Adequate Access and Capacity in Family Care

This attachment provides the documentation of how the State of WI will assure that services provided under the Family Care 1915(b) waiver are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of Family Care enrollees.

I.   Access Standards

- **Please explain**
  - **how often and how the State monitors compliance with its access and availability, appointment scheduling and the in-office waiting time standards, and**
  - **what incentives/sanctions/enforcement the State makes with each of the standards described above**

Monitoring compliance with access and availability standards

Wisconsin has not established maximum distance and travel time requirements, maximum appointment scheduling standards, or in-office waiting time standards for the Family Care waiver program because standards will vary appropriately from CMO to CMO based on geographic conditions, local practice standards, and the specific demographics of each CMO's enrollment.   In addition, due to the Family Care target populations and the unique Family Care benefit package, Wisconsin has placed an emphasis on in-home services. For these reasons, CMOs are required by contract to develop their own standards for geographic access and timeliness of access to services in the Family Care benefit package that are specific to the CMO's service area and to monitor and assess its ability to meet its standards on a continual basis.

However, Wisconsin does have a number of access and availability standards (**see Attachment 1**) that will be used as a basis for assessing each CMO's ability to make services available and accessible to Family Care enrollees. State CMO access and capacity standards are derived from two sources. First, the Family Care legislation and administrative rules contain a set of standards that pertain to a CMO's provider network. Second, the Health and Community Supports contract (the PHP contract) the department will enter into with each CMO contains a number of standards and expectations related to access and capacity. These standards will be applied as tools to assess the overall adequacy of the CMO's network in conjunction with the access and capacity performance measures contained in **Attachment 2**.

In addition, each CMO is required to use a process for assessing the needs of the populations it anticipates enrolling, the expected utilization of services for the enrolled populations, the number and types of providers needed to serve the enrollment, and the geographic location of providers and enrollees during the contract year. See **Attachment 3** for the CMO self-assessment tool for access and capacity. This tool will assist the state to gauge the capacity of prospective CMOs to coordinate and deliver the full range of services and supports to be accessed through the Family Care benefit.

CMO Access Monitoring Requirements
CMOs may use a variety of means to monitor and assess the strengths and weaknesses of its provider network related to its own access and availability standards. However, two methods must be used by each CMO. They are member surveys and tracking and analysis of member complaints and grievances.

By contract CMOs must conduct an annual member feedback on CMO performance, which means obtaining member input on a formal basis input, either through member surveys, face-to-face interviews or other means, on:
- The effectiveness of its communications with members;
- Access and availability for services in and outside of the LTC benefit package including access to residential services, adequate choice of provider, and the capacity to serve the enrolled population.
- Choice and continuity;
- Changes in functional and health status of members; and
- Other information of interest to consumers.

The results of the annual member feedback on CMO performance are made available to the Department and members upon request. The purpose of this activity is to identify successes, potential problems and barriers to care and to provide potential members with information they need to choose a CMO.

Annually, each CMO is contractually required to submit two complaints and grievance reports to the state. The first report, the summary report, is an analysis of the trends the CMO has experienced regarding types of issues complained and grieved about, and regarding specific providers that are the subject of complaints or grievances. The second report is a log which must include the following information about each complaint and grievance: whether it is a complaint or a grievance; the nature of the complaint or grievance; the timeline in which it was resolved; the decision; whether the grievance was resolved to the satisfaction of the member; whether a disenrollment occurred during the course of a complaint or grievance, and if so, the reason for the disenrollment. These reports will provide the basis for monitoring access and availability to CMO services by the CMO and the state.

State Monitoring Activities of CMO Access Standards
In addition to the tools described above, the state has its own processes for collecting and evaluating information on the availability of services to CMO enrollees. Because the assessment of provider network adequacy takes place on several levels, Wisconsin will use variety of methods that will be timed before and during the contract period.

Assessment of Access and Capacity before Initial Contract Period
As part of the precertification process, each CMO must use the process outlined in **Attachment 3** for assessing its provider network needs. In addition, each CMO, prior to initial contracting and before contract renewal, must furnish the state with the following information for each service in the Family Care benefit package: (**see Attachment 4**)
- number of providers contracted for each service
- types of providers to be used for providing a particular item or service

- the locations of service providers and whether or not the provider is located within the CMO's service area
- if the provider serves all Family Care target groups and if not, which target groups the provider serves
- the type of expertise the provider has in the area of cultural competencies, foreign languages, specialized services
- if the provider is a residential provider, its capacity and whether or not private rooms are available
- hours of service
- which providers are not accepting new clients

The state reviews the information the CMO sends in as part of the certification process (**see Attachment 5**) and ensures that all covered services are available within the CMO's network, either through employees of the CMO or providers and facilities that have entered into written agreements to serve CMO enrollees. The review process includes an on-site interview with CMO managers who are responsible for provider network contracting as well as a rigorous desk review of relevant materials that are submitted by the CMO. The review team includes state staff who have appropriate expertise, skills, experience and interest.

Each CMO's documentation is reviewed for consistency and for evidence of adequate capacity to meet Family Care regulations and state and federal managed care contract requirements. Follow up communication from the state indicates the results of the review. Results may show that the CMO's documentation was acceptable or that additional documentation is needed prior to contract signing. In some cases, a CMO may be required to participate in technical assistance sessions pertaining to network development or attend mandatory training in relevant areas. Additionally, a CMO may be required to meet performance expectations specific to its provider network during the contract period that are attached to the contract in the form of an amendment. In such cases, the state will conduct reviews and site visits as necessary to validate progress made in those areas.

Annual On-site Monitoring during Contract Period
In addition to the precertification review, on an annual basis, the state will conduct an on-site review to evaluate the geographic distribution of available service providers and whether the CMO is meeting standards for timeliness of services. As part of this review, the state will ensure that each CMO's network is structured in a way that considers the geographic location of providers and enrollees, including such factors as distance, travel time, and the means of transportation normally used by enrollees. If the CMO contracts with providers outside its service area, the CMO will have to justify these arrangements as either making it easier for some enrollees to reach the particular provider or other reasons such as inability to contract with a sufficient number of providers within the service area.

The review will consist of assessing CMO policies and procedures, documented processes, provider files on-site at the CMO's administrative offices. CMO staff interviews will also be conducted. The review team will be composed of department staff, a relevant LTC provider, a registered nurse, a social worker and a consumer if possible.

<u>Periodic Monitoring Reports</u>
The state plans to establish periodic (monthly or quarterly) CMO monitoring reports that provide information on various system level access and capacity issues (**see Attachment 6**). Annual CMO performance reports on the 17 performance measures listed in **Attachment 2** will also be analyzed to assess whether or not provider network issues exist. If problems are detected, the state will provide the CMO an opportunity to discuss and resolve them. When detected problems cannot be resolved in this manner, actions will be implemented in accordance with the PHP contract and state regulations.

Incentives to Meet CMO Network Adequacy Standards

Each CMO is required to establish standards for geographic access and timeliness of services and monitor its provider network against its standards. CMOs are required to use tools such as member surveys and analysis of member complaints and grievances and must take corrective action if a provider in its network does not conform to its standards.

The PHP contract furnishes the CMO with an incentive for acquiring and maintaining an adequate provider network that is geographically accessible to its members. PHP contract provisions state that the CMO is accountable for the availability and adequacy of all covered services. This means that, if a CMO does not have the capacity to provide services in a timely way because it does not have a sufficient number, mix and geographic distribution of providers, the CMO must have a process to provide or arrange for services with non-CMO providers. Circumstances under which this contract provision can be invoked are the following: (1) when the CMO does not have the capacity to meet the need; (2) when the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers; (3) when the CMO can not meet the need on a timely basis; or (4) when transportation or physical access to the CMO providers causes an undue hardship to the member. The CMO must then pay the non-network provider what he or she bills rather than a negotiated rate that is agreed upon through the contracting process.

<u>State Sanctions and Enforcement Options</u>
The state monitors each CMO through precertification reviews and annual on-site monitoring reviews. The state may apply one or more of the following sanctions for noncompliance with the CMO contract: corrective action plans, enrollment holds, recoupment of funds, termination of contracts, and monetary penalties.

- **Please explain how the distance and travel time, appointment scheduling, and in-office-waiting times to obtain services under the waiver will not be further or longer than prior to the waiver.**

How access is improved in Family Care CMOs

The Family Care benefit is a package of services that includes solely those services that are considered LTC services and supports. That is, acute and primary health care services, including physician, medical specialist, emergency departments and inpatient hospital are carved out of Family Care. For this reason, the state believes that the emphasis on distance and travel time, appointment scheduling, and in-office waiting times is of lesser importance than with managed care organizations that provide a comprehensive benefit package. That is not to say that access

and capacity issues are not important. Indeed, one of the primary reasons for the creation of the Family Care benefit is to improve access to LTC services for the elderly and people with disabilities. It is only to say that access and availability concerns may be different under Family Care than for the more typical managed care organization arrangements, and that as a result different access standards will be needed to improve access to LTC.

In the Family Care benefit package of services, the CMO will have the responsibility for providing a set of services to meet its enrollees' LTC needs. Capitating LTC alone offers an opportunity to meet LTC needs in innovative ways, including greater use of community-base care, and possibly new types of community based settings. CMOs must be allowed to negotiate appropriate contracts for such services without having fixed standards in place that may limit who they contract with. Therefore, the state has opted not to set distance and travel time, appointment scheduling, and in-office waiting time standards but instead to require that CMOs set these standards for providers in their networks based on consumer feedback and local practice.

Instead of setting the timeliness standards for the CMO, the state has chosen to determine the process each CMO must use to assure the availability of Family Care services (**see Attachment 3**). Using this predetermined process, each CMO assesses the needs of the potential enrolled population and establishes a network of providers that will meet identified needs. The state uses this information to evaluate whether or not each CMO's service planning and basic assumptions for determining that its network is ready to service Medicaid enrollees in its service area and is sufficient to meet the enrolled population's needs.

From year to year, the state will evaluate each CMO's provider network in terms of numbers of providers before the initial contract period and prior to renewing each contract using the forms in **Attachment 3, 4, and 5**. Marked differences in the composition of the CMO network from year to year will be questioned. CMOs will be required to explain why reductions in certain provider types have occurred without a concurrent reduction in membership. Performance reports, complaints and grievance reports, and results of member surveys will track how changes in a CMO's provider network are impacting outcomes and consumer satisfaction with services. If a particular CMO is evaluated and found to be out of compliance with the state's access and capacity standards (**see Attachment 1**), the state may develop distance and timeliness standards and require the CMO to initiate a corrective action plan to meet the imposed standards.

- ▪ **Please explain how the MCOs/PHPs will be required to enable enrollees to access providers.**

How enrollees access providers

The process of enabling enrollees access to providers begins at the time of enrollment. The Resource Center administers the LTC Functional Screen to any county resident who has a LTC need. The LTC Functional Screen identifies the member's health conditions and health related services, communication requirements, cognitive status, behavioral and mental health status, living arrangements, activities of daily living, instrumental activities of daily living, and risk status and assesses the individual's level of care. If the assessed level of care meets the functional level of care criteria for Family Care, and the individual is eligible for Medicaid, he or

she is given the opportunity to choose to join the CMO or traditional Medicaid fee-for-service. If the individual chooses the CMO, he or she signs the CMO enrollment form. The date the individual signs the enrollment form is the effective date of enrollment. The enrollment file, both paper and electronic versions, are sent to the CMO.

If the individual is currently receiving services through the Medicaid fee-for-service program, the state provides a report to the CMO on services that the individual is receiving and are currently authorized by the Medicaid prior authorization program. For these individuals, during the transition, the CMO is obligated to ensure that the member has no disruption of service. Therefore, the CMO contacts current providers and the member to evaluate service needs.

Within five working days of receiving the member's enrollment package, each CMO must furnish a service coordinator who is responsible for working with the member or his/her representative and other service providers to develop an initial plan of care. Enrollees will have an opportunity, upon enrollment, to choose his or her service coordinator and may request a change of service coordinator any time during their membership in the CMO.

During the development of the initial care plan, the CMO will review the screening information from the FFES, service records, prior authorization reports and any existing care plans to identify immediate service needs for the member. As part of this process, the service coordinator will contact the member, his or her family and/or representative, current service providers, including contacting the member's primary care provider if necessary, to ensure that the member's immediate needs are identified. The service coordinator is empowered to authorize and arrange urgently needed services until a comprehensive assessment is completed.

All new CMO members, once immediate needs are met, receive a comprehensive assessment, which must be completed within 30 days of enrollment. Service coordinators facilitate the use of appropriate specialized expertise, like therapists, for the initial comprehensive assessment, consultation, ongoing coordination efforts and other areas as needed. Service coordinators also arrange a multidisciplinary team discussion to formulate an individual service plan (ISP) which the member, the member's family, or representative signs off on.

The service coordinator serves as the integration point for identifying the member's needs via the multidisciplinary comprehensive assessment, developing the individualized plan of care based on identified needs, and implementing the care plan. The plan of care integrates all aspects of the member's physical and mental health care and LTC services and supports taking into account all input from all providers. The service coordinator works as a team with other providers to authorize and refer, using the resource allocation decision method explained in the next section, for most if not all Family Care services. Members who opt for self-directed care may authorize and are trained to coordinate their own care to the extent of the member's capability.

The mix of services and supports that evolves into the members ISP is not limited to the procurement of formal supports but also involves planning and accessing informal supports, community services, as well as necessary acute and primary care services. Once the member has authorized service coordinators to receive medical information from acute and primary care providers, the service coordinator contacts the provider to collect any information on medical or

mental health services the member is receiving. The nurse on the interdisciplinary team, who may or may not be the service coordinator, reviews the member's medical records to determine the member's clinical needs and provides input to member's individualized service plan.

The Family Care ISP integrates all aspects of the member's physical and mental health and LTC needs. The service coordinator's roll includes facilitating the coordination of care for all needed services, whether or not they are in the Family Care benefit plan. For example, if a member is having difficulty accessing medical care, the service coordinator or other member of the interdisciplinary team assists the member in arranging for needed primary and acute care services, including any necessary transportation to and from appointments. (See Continuity and Coordination of Care section below.)

On an ongoing basis, the service coordinator facilitates and coordinates all services within the Family Care benefit plan through continuous monitoring. For example, whenever there is a change in the member's condition, the service coordinator updates the member's plan of care and arranges for additional services as needed. Service coordinators speak with, via telephone, and visit the member's home several times a year. At these times, the service coordinator is able to verify that the components of the plan of care are being delivered as intended and identify new areas that may need to be addressed.

How Family Care service are authorized
The aim of managing services and supports through a care management team is not to restrict access to particular services and supports but to plan, seek and negotiate a mix of services and supports tailored for the enrollee that will be cost-effective and support the achievement of consumer defined outcomes. However, balancing consumer outcomes with cost is no easy task. To facilitate a standardized decision-making process between and among care management teams, the state has provided Family Care CMOs with guidelines for authorizing services within the interdisciplinary team. The methodology is called the "Resource Allocation Decision Method" or the RAD (**see Attachment B. 1.**). The RAD approach involves a balancing of outcomes and costs similar to current Wisconsin statutes on "least restrictive environment."

Each CMO may determine what, if any, services and supports are subject to utilization review and whether or not the enrollee may access providers of certain Family Care benefit plan services directly without team approval. If the CMO chooses to do so, it can require that certain high cost services, such as nursing home, be authorized by an entity outside the team. All utilization management activities, such as prior authorization, however, must be based on care criteria that is approved in advance by the state and be conducted by qualified individuals with knowledge in the specific area in which the coverage decision is being made. If services are reduced, limited, or denied through the process of utilization review, CMO appeals/grievance mechanisms must be in place to allow enrollees to seek redress.   Additionally, enrollees have the right to appeal to a party not controlled by the CMO.

The state recognizes that the move to managed LTC services, with its intrinsic rules about access to services, may put the enrollee at a disadvantage. That is why, in addition to the requirements that each enrollee have an opportunity to choose his or her own service coordinator, and that the CMO establish its own internal complaints and grievance process, Family Care guarantees

access to external advocacy services to help resolve problems with CMOs (see section XXX for a description of the role of the Family Care external advocate.)

II.   *Capacity Standards*

▪ **Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.**

How capacity will improve

Wisconsin does not expect the number of providers before and after the waiver to remain the same. The state does expect, however that for some provider types, the numbers of providers may increase and for others the numbers may decrease. For example, in the current fee-for-services system, controlling the number of openings or slots controls the capacity of the service system. Furthermore, fee for service payment mechanisms discourages resource sharing and alliance building which can result in duplication and excess capacity.

Under Family Care, demand for services will be based on consumer preferences and needs. This may cause a number of changes to the capacity of the LTC service and support system. For example, it may encourage new suppliers to enter the market place. Or, it may create the impetus for suppliers to seek out partners in order to remain competitive. This alliance building would have the effect of removing duplicative capacities that exist in the service system. That is why Wisconsin is proposing to use indicators (see table below), other than counting the numbers of providers and suppliers before and after the waiver, to help pinpoint where the problems are in the supplier base under the Family Care waiver program.

One of the principal goals of Family Care is to encourage a service delivery system that maximizes benefits to individuals with disabilities and their families. Initially CMOs will largely rely on the network of existing providers under the fee for service payment system. As a CMO matures and enrollees' needs and preferences for services are driving the composition of its provider network, the state will track and analyze changes using assessment tools contained in **Attachments 3, 4, and 5**. This information will be used to develop criteria, that will be used during future contract periods, to assist in determining the types and numbers of living, day and other support service providers, for example, that should be available given a particular enrollee mix. It will also be used to determine if each CMO is maintaining a sufficient supply and distribution of providers to ensure that consumers have ready access to needed services.

As this is done, it will be critically important to monitor the system for indications that each CMO's provider network is sufficient to support enrollee needs and preferences. Indicators such as calls to the Family Care 24 hour hotline, periodic enrollee surveys on access and satisfaction to services, complaints and grievances, and review of utilization data will be used to detect CMO provider network inadequacies (**see Attachment 2**).

▪ **For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before and after the waiver.**

Indicators of adequate capacity

As the CMO begins to manage the network, existing providers will be used. As services and supports are aligned to the needs/preferences of individuals rather than available services, new providers will most likely emerge to offer the services and supports existing providers are not able to provide. The effect this will have on the numbers and types of providers is unknown. Some providers, mostly smaller ones, may form alliances with other organizations to form comprehensive service and support networks. Other larger providers may convert to providing different services and supports. An example of such a shift is segregated day programs converting to providing supported employment and integrated community activities. Some of the possible changes in LTC service and support supplier base are described below. The purpose of describing some of the potential influences on the LTC provider network is to set the stage for proposing an alternative method to counting the numbers of provider types before and after the waiver. And that alternative is to collect a baseline set of outcome data in order to develop performance norms in key areas.

Institutional Providers
Since one of the goals of Family Care is to encourage the development of "community care" alternatives (personal care, home health etc.) over more costly institutional (nursing facility and ICF/MR) long term care services. As a result, in Family Care counties, the state may see significant shifts in the utilization of institutional services, which may or may not have an effect on the total number of institutional provider or available beds in operation.

Direct service staff
CMOs will be expected to manage the full complement of LTC support services including residential services, in-home supports, and day services as well as work, participation in community activities and related areas of community living. Direct service staff are residential and day workers, attendants, job coaches, vocational trainer, therapists counselors and other who spend the great majority of their time with consumers. Numbers of direct service staff should increase as CMO enrollment increases.

However, the actual number of direct service staff will continually change from month to month. Furthermore, many direct service staff who are providing services to Family Care enrollees will be employed by provider agencies that subcontract with the CMO. Providing an accurate count of direct service staff before and after the waiver is not feasible.

Community and natural supports
Managing the "paid system" is only one piece of the support providing equation that CMOs will be accountable for. The Family Care model, unlike typical managed care service packages, is not clinically based: that is, it will not necessarily revolve around health care treatments and providers who provide medical care.

LTC support needs are met in a variety of ways. Frequently, natural supports can be used in lieu of paid staff. Availability of family members and friends to help, availability and accessibility of other community resources needs to be factored in to the equation. However, counting the number of natural supports before and after the waiver would prove to be excessively burdensome.

Care coordination

Wisconsin believes that the care coordination features of Family Care will improve access to preferred health care providers. Under managed care, CMO case managers can arrange for alternative services that may not have been available or could not readily have been covered directly under the state's Medicaid program or its 1915 (c) waiver programs.

Proposed indicators for monitoring CMO capacity

Wisconsin would like to propose that the following indicators be tracked in order to determine how the LTC provider/supplier base changes as a result of the waiver.

Family Care Geographic Areas	Milwaukee County		Fond du Lac County		La Crosse County		Portage County		Richland County		Marathon County		Waukesha County		Forest/ Oneida/ Vilas Ctys	
% of members using Family Care providers	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2	Y1	Y2
Institutional providers-NF																
Institutional providers-ICF-MR																
Residential providers – AFH																
Residential providers – CBRFs																
Residential providers – RCAC																
Ratio of enrollees to care management teams																
Supportive employment																
Prevocational services																
Personal care workers																
Supportive home care workers																
Informal supports																

Accessing mental health and substance abuse services

Outpatient mental health and substance abuse services that are provided by non-physicians are a Family Care covered benefit. Typical services covered under the benefit are counseling and

therapies that are provided in an outpatient setting, in the member's place of residence or other facility. CMOs may directly furnish these services or contract with mental health/substance abuse professionals/agencies. Psychiatric inpatient services and mental health and substance abuse services provided by physicians and psychiatrists are not a Family Care benefit.

As with all other Family Care benefit plan services, enrollees access mental health/substance abuse services through a designated care management team which, at a minimum, consists of a social service coordinator and a registered nurse. Mental health/substance abuse services may be access through approval by the care management team or directly, that is, without team approval, depending on the policy of the CMO.

Moreover, each CMO may determine which, if any, mental health/substance abuse services are subject to utilization review. As with all utilization management activities, decisions on coverage must be based on care criteria that is approved in advance by the state and only qualified individuals with knowledge in the specific area in which the coverage decision is being made may render a decision. If mental health/substance abuse services are reduced, limited, or denied through the process of utilization review, CMO appeals/grievance mechanisms must be in place to allow enrollees to seek redress.   Additionally, enrollees have the right to appeal to a party not controlled by the CMO.

III.   *Continuity and coordination of care standards*

The CMO's care management team is formally designated as being primarily responsible for coordinating the member's overall long term care and health care. In accordance with the plan of care, the care management team authorizes, provides, or arranges for or coordinates services in the LTC benefit package, and coordinates all other needed services identified in the individual service plan (ISP), in a timely manner. Coordination of services also includes ensuring that informal support services are involved appropriately and in accordance with the member's preferences. The CMO also ensures coordination of services internally and with services available from community organizations and other social programs.

Every CMO member receives care management services through a care management team that is either chosen by the member or assigned by the CMO. The team, at a minimum, consists of a social services coordinator or social worker, and a registered nurse. Providers with appropriate specialized expertise such as physical therapists, occupational or speech therapists are used as needed for the initial comprehensive assessment and on-going re-assessments and care planning. The social service coordinator must have a minimum of a four-year bachelor's degree in the social services area (e.g., social work, rehabilitation psychology, etc.) and have knowledge of the target group being served as well as knowledge of the full array of community services available.

Within five days of the effective date of enrollment of a new member, CMO care management staff will have face to face contact with the person and perform a risk assessment to determine if the person needs urgent or immediate long term care services. CMO care management staff will work closely with independent enrollment contractor's enrollment counselors to identify areas where the new member may need long-term care supports before the completion of the comprehensive assessment and development of the initial service plan.

Care management covers three major areas of activity; assessment; care planning and implementing the individualized service plan; and on-going monitoring. The service coordinator facilitates and/or coordinate the assessment and implementation of the individualized care plan by sharing information with other team members, creating a timetable for completion of certain activities, arranging for the resources to be available, preparing the member and reporting on their completion and effect. The care manager should be able to maintain a high level of contact with the member and involve the member, family, and all CMO staff who are considered to be part of the team and all providers in all settings in carrying out the plan of care.

Assessment
The comprehensive assessment is a process of identifying the unique physical health, mental health, and long term support needs of the member. The member or the member's responsible party is central to the assessment process. The CMO assesses and documents the member's choices and desired outcomes for each identified need. The care management team encourages the active involvement of any informal supports in the assessment as desired by the member. The care management team has 30 days from date of enrollment to complete an initial comprehensive assessment.

The care management team will receive from the independent enrollment contractor during the enrollment process, a copy of the Long Term Care Functional Screen. Without duplicating information, the comprehensive assessment will gather information in the following areas: activities of daily living, physical health, nutrition, autonomy and self-determination, communication, mental health and cognition, presence of informal supports, members rights and responsibilities, community integration, safety, personal values, education and vocational activities and economic resources. The care management team and the member will use the results of the assessment to identify the services needs and develop the Individual Service Plan.

Care Planning
The Individual Service Plan is completed within 60 days of the enrollment date and includes the following: services or interventions to be provided, in order to meet the identified needs and honor the preferences identified in the comprehensive benefit package; coordination (time and frequency) of services outside the benefit package, (including but not limited to Medicare services, school based services, vocational rehabilitation services and third party insurance coordination); type of residential setting; the party responsible for providing each service or intervention, the expected outcomes and the specific time period covered by the ISP. The interdisciplinary team is empowered to authorize most if not all LTC services in the Family Care benefit package. The state has provided a tool to CMOs for allocating LTC resources which is called the Resource Allocation Decision Method. **(see Attachment B.1.)**

The CMO is responsible for furnishing services in the long-term care benefit package based on the ISP, and coordinating all other services provided to the member from the day of enrollment. The ISP addresses comprehensive service needs regardless of whether the service is covered in the long-term care benefit package or through another funding source. The ISP is reviewed with and signed by the member, or the member's authorized representative as appropriate, to indicate his/her agreement with the ISP. The CMO provides the member with a copy of the signed ISP. For new members who are currently receiving services through their regular Medicaid card, that

are now part of the benefit package, the CMO shall make every effort to identify those services prior to the enrollment start date, and is obligated to ensure that the member experiences no disruption with the services needed to assure health and safety.

Coordination of services not in the benefit package
The CMO teams will build relationships with providers not in the benefit package (services that are carved out of the Family Care Benefit). At a minimum the team nurse, within 30 days of enrollment, documents the person's primary physician, specialty care provider(s) and psychiatrist (if applicable). The team contacts all primary providers to educate them on the CMO services available to their patients, and how to access services. The team is responsible for getting signed releases in order to access the member's medical records to complete the comprehensive assessment, and educate members on the effective use of primary and specialty care, and use of emergency services.

 The team also is responsible for assisting the member to access primary and acute services not in the benefit package, and facilitating that access. Throughout the process, the care management team acts as the advocate of the member regularly communicates with primary and acute care providers to effectively promote the member's health and well being. The CMO must have in place protocols for inter-disciplinary teams to share information when members receive services from more than one primary provider, to ensure coordination of emergency and urgent care services with the LTC services received by the member through the CMO, and processes for creating and coordinating follow-up treatment plans.

 When a member is admitted to a hospital or nursing facility, the team assesses the member's condition within one week. Each CMO must develop protocols for sharing relevant health records between facilities/institutions to avoid duplication and facilitate continuity of care between the member, family, facility and other health care providers. It is the team's responsibility to facilitate coverage between payers (private insurance, Medicare and Medicaid) to assure seamless receipt of services by the member. The team also monitors and coordinates prescription medications, assesses risks associated with multiple medications and multiple primary providers, and educates the member on drug interactions.

Ongoing monitoring
Ongoing monitoring is the process of verifying that services are being provided as provided for in the care plan, and assessing the quality of service delivery. The team will be responsible, as laid out in the ISP, for the outcomes of the services delivered, and determining periodically if the services continue to meet the members needs and outcomes, and making adjustments to services when necessary.

Monitoring involves regular contact with the member, caregivers, and others who play a significant role in the member's life. Regular contact is vital to the continuity of service and maintaining a relationship with the member that facilitates the identification of changing needs, preferences and concerns of the member. The ISP will lay out the individual monitoring plan for each member. Frequency of contact will depend on the stability of the member's health, living situation and informal supports, as well as the preference of the member for amount of contact from the team needed to meet their identified outcomes. At a minimum, the member and the

interdisciplinary team will review the care plan at least once every six months. Re-assessments will be performed as necessary to ensure the optimum health and well being of the member. In addition, the functional level of care and financial eligibility of the member for Family Care, will be re-determined annually by the Resource Center. In redetermining eligibility for both Medicaid and Family Care, the Economic Support worker in the Resource Center will ask enrollees for any changes in financial status, and will evaluate any changes in the functional screen which are reported by the enrollee's CMO case manager.

Prevention and wellness
Prevention and wellness will be part of the normal course of on-going monitoring and general communication with members, and part of the assessment and planning process for each member. The team will work with each member to educate them on the contributions they can make to their own health and the proper use of long term care and health services. The CMO must submit a plan for implementing their prevention and wellness program to the Department of Health and Family Services and it must be approved prior to the signing of the contract.

Counseling and therapeutic services
Counseling and therapeutic services are part of the Family Care benefit plan and are services the CMO must have available on referral from providers and staff. When the team identifies a member who is unable to, or is failing to, cooperate in his or her own service plan, a referral should be made. Such counseling services might include identification of social, financial, or other barriers that are preventing members from following guidance or instruction from providers.   Once the barrier is identified, a follow up referral to the appropriate social service agency should be made.

Continuity and coordination of care monitoring
▪ **How often and through what means does the State monitor the coordination standards checked above?**

The state will monitor CMOs' compliance with continuity and coordination of care standards through periodic precertification reviews, program compliance audits, on-site reviews, member outcome reviews, consumer satisfaction interviews, and complaint and grievance investigations.

Member outcome reviews will be conducted on a routine basis by either state staff or contracted agencies. A sample of members will be contacted through home visits to determine if services are being delivered according to the ISP, assess the level of member compliance to prescribed treatments and satisfaction with each service being delivered, identify service problems that need follow up, determine if changes are needed to the members ISP, and identify members at risk who need more frequent monitoring or referrals to other services. The review team will also assess whether or not the member is aware of and taking advantage of preventive health maintenance opportunities. If state staff observe persistent services delivery problems or patterns of poor service quality, the CMO is contacted and a formal response is requested. (See Section C. for a description of the state's monitoring and oversight plan.)

Coordination of services excluded from the Family Care benefit package

▪ **How does the state require the CMO to coordinate health care services excluded from the waiver?**

For members who are Medicaid beneficiaries, the CMO will arrange for services not covered in the LTC benefit package from other sources and instruct all members on where and how to obtain them, including how transportation is provided. The CMO coordinates these services for its members through the care management team. The service coordinator obtains the member's authorization to request information from other providers currently providing services to the member. It is also the teams' responsibility to assess whether or not the member is having difficulty accessing service outside the Family Care benefit plan. If this is the case, the team will assist the member to arrange for needed services.

The care management team will also work with community organizations that may not be providing Family Care services but are other wise important to the health and well being of members. These include but are not limited to nutritional assistance programs, social service agencies, and civic and religious organizations. It is also the team's responsibility to identify the preventive health care goals of the member and provide education and supportive services through such agencies as local health departments.

Each CMO must have plan for providing information on CMO program requirements and how to access CMO services to providers who provide services outside the Family Care benefit plan and community providers. At the member's request, the CMO will provide other involved providers with the ISP so that services can be better coordinated. The comprehensive assessment will reveal specific mental health, substance abuse, dental, and medical transportation needs. This knowledge will guide team members to better assist members to obtain services outside the Family Care benefit plan.

CMOs will also require that each member have easy access to information that might be needed by acute and primary care providers, such as current medication lists. The care management will assist the member in compiling all pertinent information, past and current, so that the member is able to have this information available to take to appointments or in the event of a sudden need for medical services.

Attachment 1

Waiver Program Access and Capacity Standards

	Family Care CMO Access and Capacity Standards	Reference
1.	By the effective date of this contract, the CMO shall demonstrate to the Department an adequate capacity to provide the projected membership in the service area with: • the appropriate range of services; • access to prevention and wellness services; • a sufficient number, mix and geographic distribution of providers of services; • specialized expertise with the target population(s) served by the CMO; • culturally competent providers; and • services that are physically accessible and available on a timely basis.	PHP contract
2.	The CMO shall develop standards for geographic access and timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by HCFA or the Department.	PHP contract
3.	The CMO shall maintain a process to consider a member's request for a non-CMO provider in at least the following instances: ▪ when the CMO does not have the capacity to meet the need; ▪ when the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers; ▪ when the CMO can not meet the need on a timely basis; or ▪ when transportation or physical access to the CMO providers causes an undue hardship to the member.	PHP contract
4.	ASSURANCES OF ADEQUATE AVAILABILITY OF PROVIDERS. Each CMO applicant must assure the department that it has adequate availability of qualified providers with the expertise and ability to serve the expected enrollment, in a timely manner, in its service area.	Family Care Emergency Adm. Rule
5.	DETERMINING ADEQUATE AVAILABILITY OF PROVIDERS. A CMO applicant is determined to have adequate availability of qualified providers and a sufficient capacity to develop services to implement individualized service plans that meet the needs of particular individuals in the CMO if— a. It has written agreements with individual providers or provider systems that provide key types of health and long term care services and supports. Key LTC provider types are residential, home support, day and vocational, respite care, and transportation providers. b. It has appropriate provider agency connections to qualify providers, on a timely basis, who are needed to directly reflect the specific needs and preferences of particular enrollees.	Family Care Emergency Adm. Rule

	Family Care CMO Access and Capacity Standards	Reference
	c. It has staff (or via written subcontract) assigned to provider recruitment, selection and retention and for training new providers in a timely fashion. D. It has staff (or via written subcontract) to coordinate residential placements who has shown capability in recruiting, establishing, facilitating placements with appropriate matching, and for providing ongoing support (and respite) for residential care facilities.	
6.	PROCESS FOR ASSURING ADEQUATE AVAILABILITY OF PROVIDERS. In establishing and maintaining an adequate network of available CMO providers, the CMO applicant must provide documentation that it has considered the following: a. An estimate of the anticipated CMO enrollment, by Family Care target group, for the initial year of operation and each subsequent year it has a CMO contract with the department. This estimate must be used in developing the CMO provider network and for assuring the department that the CMO applicant is able to develop individualized service plans that include qualified providers and care settings that directly reflect the needs and preferences of CMO enrollees. b. The geographic locations of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by CMO enrollees, and whether the location provides physical access for enrollees with disabilities. C. The cultural orientations and language barriers of significant CMO sub-populations within the anticipated or actual enrolled population that may experience special barriers in accessing service.	Family Care Emergency Adm. Rule
7.	NATURE OF ASSURANCES. Each CMO applicant must submit all documentation required by the department, including comments it has obtained from the Local LTC Council(s) in the area it proposes to serve, at least every 2 years, and, specifically— (i) At the time it enters into or renews a contract with the department, and (ii) At any time the department determines there has been a significant change in the CMO's service delivery network or enrollee population.	Family Care Emergency Adm. Rule
8.	APPLICATION FOR CERTIFICATION. Entities applying for initial certification and for renewal of certification as a CMO shall submit an application in a form prescribed by the department. The applicant shall address the following: CMO HOURS OF OPERATION. The CMO applicant's hours of operation must be sufficient to meet the needs of enrolled recipients. ▪ Each CMO applicant must submit documentation to demonstrate that it has the capacity to assure that it can provide or arrange for the provision of services in the Family Care benefit in whatever manner is prescribed in individualized service plans of CMO	Family Care Emergency Adm. Rule

	Family Care CMO Access and Capacity Standards	Reference
	enrollees. The CMO must also have a process for intervening when necessary if provider availability is compromised and enrollee health, safety and welfare are put at risk. ▪ Each CMO applicant must submit documentation that shows it can provide for reasonable and adequate hours of operation for information and referral services, and for handling complaints and grievances.	
9.	ACCESS STANDARDS. The CMO applicant must meet and require its providers to— ▪ Meet all standards established by the department in the course of the general contract negotiation process for timely access to care and enrollee services; ▪ Establish mechanisms to ensure compliance with established access standards; ▪ Monitor continuously to determine compliance; and ▪ Take timely corrective action if there is failure to comply.	Family Care Emergency Adm. Rule
10.	CMO SERVICE AREA EXPANSION. If seeking expansion of its service area, a CMO must submit documentation to demonstrate that it has sufficient numbers and types of providers to meet the anticipated additional volume and types of services the added enrollee population may require.	Family Care Emergency Adm. Rule
11.	RESIDENTIAL AND DAY SERVICES. Each CMO applicant must submit documentation to demonstrate that it offers an appropriate range of residential and day services that are geographically accessible to proposed enrollees' homes, families, guardians or friends taking into account regional resources and populations.	Family Care Emergency Adm. Rule
12.	SUPPORTED LIVING ARRANGEMENTS. Supported living arrangements are in-home supports furnished to enrollees in their own residences or in the family home. Each CMO applicant must submit documentation to demonstrate that it has the capability to access providers who can train and deploy qualified staff in a timely fashion to support CMO enrollees in their place of residence taking into account regional resources and populations .	Family Care Emergency Adm. Rule

Attachment 2

Waiver Program Performance Measures Related to Access and Capacity

CMO Performance Measures That Relate to Access and Capacity
1) % of members who voluntarily disenroll because they are dissatisfied with the CMO.
2) % of personal care workers (PCW) added to CMO provider network to accommodate members' choice of PCW.
3) % of people reporting that they have access to the supports they need to maintain their independence.
4) % of members who have used paid staff for help at home who report that they chose/hired the paid staff who help him/her at home (e.g., personal care worker, supportive care workers).
5) % of members receiving supported employment services, etc.
6) Transportation options available to members and utilization by type.
7) % of members who are relocated into the community from an institutional setting.
8) % of members who report having adequate transportation.
9) % of informal supports, who are the primary caregiver, who state that they are getting the help that they need (includes respite, home care, education, and emergency back-up services).
10) % of members who report that the locations of certain specific health services and supports are convenient (e.g., day centers, congregate meals, transportation, etc).
11) % of members who have a regular doctor or a regular source of primary care.
12) % of care management team members (i.e., social service coordinator and RN) who separated during the reporting period.[1]
13) % of members who have had a visit to a primary care physician in the last year.
14) % of members how report that they were offered an opportunity to receive an influenza vaccine in the last year.
15) Staff turnover rate for personal care workers.
16) % of members who report that the CMO responds promptly to their service needs.
17) % of members who have an ER visit for ambulatory care sensitive conditions.[2]
18) % of members who have a hospital stay that may have been preventable.[3]

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[1] Separation is defined as movement out of an organization (i.e., it includes resignations as well as terminations). Separations do not include transfers or promotions within an organization.

[2] Conditions for which hospitalizations can be largely prevented with consistent, available ambulatory care and adherence to treatment/self-care protocols: angina, asthma, bacterial pneumonia, cellulitis, chronic obstructive pulmonary disease (COPD), congestive heart failure, convulsions or seizures, dehydration, diabetes, failure to thrive, gastroenteritis, hypertension, hyoglycemia, immunization related conditions, iron deficiency anemia, kidney/urinary infection, nutritional deficiencies, severe ear, nose and throat infections, and tuberculosis.

[3] A hospital stay that may have been preventable is the term used to describe inpatient hospital admissions for the ambulatory care sensitive conditions described above.

Attachment 3

<div align="center">

Waiver Program Access and Capacity Assessment Tool
CMO Precertification Self-Assessment for
Provider Network Capacity and Availability[4]

</div>

I. Adequate Capacity
Contract Requirement: **By the effective date of this contract, the CMO shall demonstrate to the Department an adequate capacity to provide the projected membership in the service area with:**
- **the appropriate range of services;**
- **access to prevention and wellness services;**
- **a sufficient number, mix and geographic distribution of providers of services;**
- **specialized expertise with the target population(s) served by the CMO;**
- **culturally competent providers; and**
- **services that are physically accessible and available on a timely basis.**

Evidence of adequate capacity to serve the membership is as follows:

MA Card Services: For services in the LTC benefit package that are defined under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code, evidence of adequate capacity to serve the membership is by subcontractual relationships with providers or ability to provide the service directly.

HCBW Services: For the remaining services in the LTC benefit package (1915[c] waiver services), evidence of adequate capacity to serve the membership is by:
- subcontractual relationships with providers,
- ability to provide the service directly, or
- an Adequate Service Coverage Plan which details the CMOs ability to provide adequate coverage of these services, and which is approved by the Department.

A. Sufficient Number of Providers
A1) What is the projected census, by target group, at the end of the each quarter?

A2) What portion of your anticipated enrollment by target group will use this service?

A3) What is the estimated utilization of service (for each benefit) *in the first quarter*? (How are you estimating utilization: what standards or norms are you basing your expected level of demand on?)
        [example: 30 hours of supportive home care per member per month]

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[4] CMO contract requirements are in bold face type.

A4) What capacity to provide the service will be required from the provider network and CMO in the first quarter? *[example of a response: 100 hours PMPM]*

- What is the aggregate number of providers needed to serve your anticipated enrollment?
- What is the aggregate number of providers available and accessible to members, either employed or under contract with your CMO?

B. Appropriate Range of Services; Expertise with Target Population

B1) What are the specific needs of your target population(s) in regard to this service?

B2) What is the appropriate range of types of providers for this service (including programmatic philosophies).

B3) Is there an adequate availability of providers of this service that are able and willing to perform all the tasks likely to be identified in the proposed enrollees' ISPs?

B4) Does the CMO have ability to develop strong linkages with systems and services that are not directly within the scope of the CMO's responsibility but that are important to enrollees needing this service?

B5) Has the CMO investigated methods for maximizing informal and community resources for this service?

C. Standards for timeliness and geographic access
Contract Requirement: **The CMO shall develop standards for geographic access and timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by HCFA or the Department.**

C1) Has the CMO established standards for travel and distance times for any of the services listed in the Family Care benefit package? If so, what are they?
- Is there accessible and affordable transportation available to the person?
- What is the time a member would spend commuting from the furthest point in the county to get the service?
- What is the CMO's standard for the maximum time spent commuting to get to a service?

C2) How does the CMO plan to establish and monitor provider compliance with these standards?

D. Accessible Services
D1) Have you identified any potential barriers in accessing the services listed in the Family Care benefit package for your anticipated enrolled population or a sub-population? (e.g., homeless, racial or ethnic norms, language, distance, travel time,

transportation, etc.) If so, describe the approach you plan to use to improve access for these specific groups.
- For example, can the member who uses an electric wheelchair physically access the service?

D2) What arrangements have you made with any providers for after-hours non-emergency services that may be required immediately because of unforeseen needs of the CMO member?

D3) Has the CMO established standards for timeliness of response to requests for the services listed in the Family Care benefit package? If so, what are they and how does the CMO plan to establish and monitor provider compliance with these standards?

- For example, What is the longest period of time a member would need to wait to get the service once it is approved?

F. Cultural Competency
Contract Requirement: **The CMO shall permit members to choose providers from among the CMO's network based on cultural preference.**

F1) What is the CMO's plan for assuring culturally competent[5] services? Consider the following:

- How will the CMO identify significant sub-populations within the enrolled population that may experience special barriers in accessing LTC services? For example:
  - the homeless;
  - enrollees who are part of a culture with norms and practices that may affect their interaction with the mainstream health care system;
  - members of a racial or ethnic minority group.
- How will the CMO make continued efforts to improve accessibility of both LTC services and CMO member services for the groups identified?
- How will the CMO give racial and ethnic minority concerns full attention beginning with the first contact with an enrollee, continuing throughout the care process, and extending afterwards when care is evaluated?
- For each racial or ethnic minority group, how will the CMO's ensure the provider network will include an adequate number of providers, commensurate with the population enrolled, who are aware of the values, beliefs, traditions, customs, and parenting styles of the community?

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[5] Cultural competency means the development and provision of care and services for diverse populations, and a demonstrated awareness and integration of health related beliefs and cultural values, disease incidence and prevalence, and appropriate management and prevention of disease.

II. Network and Non-Network Providers

A. Provider Network Listing for Consumers
Contract Requirement: **The CMO shall provide information on its provider network listing to members which includes:**
- **provider name (individual practitioner, or agency as appropriate);**
- **provider location, and telephone number;**
- **services furnished by the provider;**
- **whether the provider is accepting new CMO members or not; and**
- **information on the extent to which members may obtain services outside of the provider network**

A1) For each provider in the CMO network for a specific service:
- Are any providers not accepting new clients?
- Are any providers located outside of the CMO service area? If so, what is the justification for using a provider outside of the approved CMO service area?

B. Non-CMO Providers
Contract Requirement: **The CMO shall maintain a process to consider a member's request for a non-CMO provider in at least the following instances:**
- **when the CMO does not have the capacity to meet the need;**
- **when the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers;**
- **when the CMO can not meet the need on a timely basis; or**
- **when transportation or physical access to the CMO providers causes an undue hardship to the member.**

E1) What is the process for members to request and, if appropriate, obtain services outside on the provider network.

Certification Requirements for Specific Program Areas

CMO has a process to ensure that Case Management staff, either directly or through contract, receives training in the Family Care philosophy of consumer directed care as outlined by the Department in the guiding principles.

A. Assessment and Case Management

A1) CMO has a process in place to meet the requirements of the comprehensive assessment as described in the contract (either by using the sample assessment tool provided by the Department, or by using a tool that meets all the requirements in the contract).

▪ If the CMO is not using the sample assessment provided by the Department, has it discussed its tool with Department case management staff (Alice, Ann).

A2) CMO has a process to ensure that Case Management staff, either directly or through contract, receive training in the Family Care philosophy of consumer directed care as outlined by the Department in the guiding principles.

A3) CMO's business plan includes building capacity in case management so that enough case management time is available to
- provide consistent access for enrollees to case management services,
- assure responsiveness and flexibility;
- provide adequate monitoring of health and social needs of enrollees,
- participate in team meetings to enhance coordination of care.
- conduct intervention and prevention activities, and
- attend needed meetings with other provider agencies in the community.

What methodology will the CMO use to determine needed ratios of case management teams to consumers, and of nurses to care managers on the teams?

A4) CMO has available for the assessment process professional staff in all disciplines included in the benefit package, e.g., OT, PT, Speech, etc. For instance, an OT or other trained person could perform home assessments to identify access problems and solutions for individual consumers.

B. Home Health - Nursing Services – OT/PT/Speech Therapy

B1) CMO will has the ability to provide (either directly or by subcontract) the following services to members:
- Home Health Aide Services
- Private Duty Nursing Services
- Skilled Nursing Services
- OT, PT, Speech

C. In-Home Direct Care Workers (Daily Living Skills Training, Personal CareWorkers, Supportive Home Care)

C1) Given the shortage of direct care workers throughout Wisconsin, CMO has recruitment strategies that include recruitment of family members, neighbors, and back up plans which provides for availability of emergency staff in bad weather to isolated individuals.

C2) CMO will provide through contract, 24 hour care when appropriate and necessary

D. Nursing Facility

D1) CMO has more than one nursing facility which is licensed as a Medicare SNF to accommodate CMO enrollees and provide choice.

D2) CMO can provide nursing facility care within reasonable geographic distance to ensure sustained linkages with enrollees' family and friends.

E. Residential Services: Intermediate Care Facility for People with Mental Retardation (ICF/MR), Residential Care Apartment Complex (RCAC), Community Based Residential Facility (CBRF), Adult Family Home

E1) CMO has available a range of residential choices including RCACs, CBRFs and AFHs with specialties in developmental disabilities, mental illness, dementia and physical disabilities.

E2) CMO has residential facilities that can offer single rooms to residents when preferred by enrollees.

E3) CMO has the ability to develop individualized supportive community residential settings, such as supported apartments.

F. Linkages:

F1) CMO has MOUs with services and systems, including Medicare providers that enhance the ability of the case managers to coordinate services across systems (e.g. hospital discharge process, nursing home discharge process, primary care clinics, etc.).

F2) CMO will have linkages with hospital and nursing home staff (including discharge planners) to ensure continuity of care for enrollees.

Attachment 4

Family Care CMO Provider Network Listing

Type of service	Provider name	Address & phone	"✓" Not Taking new members	"✓" Individual subcontract submitted to the Dept.	"✓" Template subcontract submitted to the Dept.	Date contract expires	"✓" Internal CMO capacity	"✓" Addressed in Adequate Service Coverage Plan

Attachment 5

DHFS/OSF/CDSD CMO Precertification Assessment Tool
CMO Provider Network Review

1. Does the CMO has adequate capacity in its provider network to serve the projected membership.

   Definition of Adequate Capacity:
   <u>Contract Requirement</u>: By the effective date of this contract, the CMO shall demonstrate to the Department an adequate capacity to provide the projected membership in the service area with:
   * the appropriate range of services;
   * access to prevention and wellness services;
   * a sufficient number, mix and geographic distribution of providers of services;
   * specialized expertise with the target population(s) served by the CMO;
   * culturally competent providers; and
   * services that are physically accessible and available on a timely basis.

   Evidence of adequate capacity to serve the membership is as follows:

   <u>MA Card Services:</u> For services in the LTC benefit package that are defined under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code, evidence of adequate capacity to serve the membership is by subcontractual relationships with providers or ability to provide the service directly.

   <u>HCBW Services:</u> For the remaining services in the LTC benefit package (1915[c] waiver services), evidence of adequate capacity to serve the membership is by:
   * subcontractual relationships with providers,
   * ability to provide the service directly, or
   * an Adequate Service Coverage Plan which details the CMOs ability to provide adequate coverage of these services, and which is approved by the Department.

(Contract addendum will include a clause that the CMO attests that their provider network is adequate prior to entering into the HCS contract.)

2. Projected enrollment April 1, 2000:   _____

   Projected enrollment December 31, 2000: _____

Target Group Breakdown:

_____
_____
_____

3. Has the CMO identified any specific needs of its target population that should be reflected in the provider network? What are the specific needs of your target population(s) in regard to this service?

4. <u>Case Management Capacity:</u>
Does CMO's business plan includes building capacity in case management so that enough case management time is available to
- provide consistent access for enrollees to case management services,
- assure responsiveness and flexibility;
- provide adequate monitoring of health and social needs of enrollees,
- participate in team meetings to enhance coordination of care.
- conduct intervention and prevention activities, and
- attend needed meetings with other provider agencies in the community.

What methodology will the CMO use to determine needed ratios of case management teams to consumers, and of nurses to care managers on the teams?

5. Does the CMO plan to have subcontracts in place by 4/1/00 with all the T19 providers on the list?

6. Are all the T 19 providers MA-certified? Do all waiver providers meet waiver qualifications?

7. Does the CMO have capacity to offer the following services 24-hour a day, 7 day/week:

- Personal Care _____
- Supportive Home Care _____
- Home Health _____
- Transportation _____

8. Review of the provider network list and determine if capacity is:

Adequate: Sufficient to cover the service. No additional contractual requirements.

Marginally adequate: Only sufficient at the onset of the contract, and expansion/improvements are needed during first contract period. Additional contract requirements will be put in contract addendum. Specify what those additional requirements are.

Inadequate. The CMO must gain sufficient capacity in this area before entering into the HCS contract.

CMO Provider Network Review

Family Care Benefit Package Service	Follow-Up Questions for CMO	Concerns	Is CMO capacity Adequate for this service?	If CMO capacity is Marginally Adequate for this service, what requirements should be put in contract addendum?	If CMO capacity is Inadequate for this service, what improvements must be made before entering into HCS contract?
Adaptive Aids					
Adult Day Care					
AODA Services					
Comm. Aids/ Interpreter Svcs.					
Community Support Program					
Counseling & Therapeutic Resources					
Daily Living Skills Training					
Day Svcs. /Treatment					
DME					
Home Health					
Home Modifications					

Family Care Benefit Package Service	Follow-Up Questions for CMO	Concerns	Is CMO capacity Adequate for this service?	If CMO capacity is Marginally Adequate for this service, what requirements should be put in contract addendum?	If CMO capacity is Inadequate for this service, what improvements must be made before entering into HCS contract?
Meals (Home Delivered, Congregate)					
Mental Health Services					
Nursing Facilities					
Nursing Services					
Occupational Therapy					
Personal Care					
Personal Emergency Response					
Physical Therapy					
Prevocational Services					
Protective Payment and Guardianship Services					
Residential Services (ICF-MR, RCAC, CBRF, AFH)					
Respite Care					
Specialized Medical Supplies					
Speech & Language Pathology					
Supported Employment					

Family Care Benefit Package Service	Follow-Up Questions for CMO	Concerns	Is CMO capacity Adequate for this service?	If CMO capacity is Marginally Adequate for this service, what requirements should be put in contract addendum?	If CMO capacity is Inadequate for this service, what improvements must be made before entering into HCS contract?
Supportive Home Care					
Transportation					

Attachment 6

Family Care Monitoring Plan: System Level Indicators

- Purpose: Provide DHFS managers with information on a regular basis to facilitate ongoing Family Care decision-making.

- ➢ "DHFS Managers" = FC Managers Team & Executive Team
- ➢ "information" = a few key performance indicators (see below)
- ➢ "regular basis" = monthly or quarterly
- ➢ "decision-making" = related to Family Care "big picture"

- The FC Management Report is not intended to replace:

- ➢ Contract monitoring
- ➢ DHFS licensing, regulation, certification monitoring
- ➢ Routine fiscal audits
- ➢ Family Care Evaluation
- ➢ Other Family Care QA/I efforts

- Proposed key performance indicators include:

1. Cost and utilization rate comparisons between Family Care participants and comparable MA fee-for-service populations for the following service categories:

- ➢ Nursing Homes
- ➢ Home Care (e.g., home health, personal care, etc.)
- ➢ Therapies (PT, OT, ST)
- ➢ Durable Medical Equipment and Supplies (DME, DMS)
- ➢ Physician services
- ➢ Pharmacy
- ➢ Hospital
- ➢ Emergency room

2. Long-term care (LTC) Per Eligible Per Month (PEPM) cost comparisons:

- ➢ Family Care population to comparable MA fee-for-service population
- ➢ Family Care counties to non-Family Care counties
- ➢ Overall LTC PEPM to projections and over time

3. Other cost indicators (comparing Family Care experience to projections):

- ➢ CMO enrollment and capitation payments
  - ➢ CMO service-related expenditures
- ➢ Independent enrollment contractor contacts and costs

➢ Total Family Care participants and costs
➢ MA fee-for-service long-term care (LTC) users and costs
➢ MA fee-for-service primary/acute utilization and costs (for FC and non-FC LTC users)

4. Population indicators:

➢ FC eligible at comprehensive or intermediate level of care
➢ FC eligible and entitled on basis of APS need (i.e., intermediate level and APS)
➢ FC ineligible (functionally or financially)
➢ Financially ineligible for FC, but choose to participate (i.e.,100% private pay)
➢ FC eligible with cost share and average cost share amount
➢ FC eligible, but choose COP, Waivers, MA fee-for-service, or no assistance
➢ FC eligible, new to Medicaid
➢ FC eligible, switch from Medicaid fee-for-service

5. Service delivery indicators:

➢ Timely determinations of functional level of care assessments (independent enrollment contractor)
➢ Timely FC assessment and care plan development (CMO)
➢ Timely FC service provision (CMO service network)

6. Consumer satisfaction indicators:

➢ CMO disenrollments (voluntary & involuntary) and associated reasons
➢ Complaints/Grievances/Appeals, associated reasons and outcome